MEDCHI COMMENTS ON TASK FORCE "OPTIONS" DOCUMENT
("REQUIRED AREAS FOR RECOMMENDATION")

Option No. 2: Messenger Model - This is a series of proposals to encourage the "messenger model" for fee negotiations between physician practices and insurers in order that physician practices can achieve higher fees. This "Option" has been available for years under the Federal Anti-Trust laws and MedChi believes it holds very little promise for realistic assistance. The "messenger model" has not proven effective in other states and, indeed, in Delaware resulted in indictments on the basis that participating doctors had not followed the legal requirements of the "messenger model." As noted in the "Options" document itself, physician organizations including the American Medical Association have no confidence in the efficacy of the messenger model.

MedChi supports option 1.3 to establish a Physician Practice Development Program (See MedChi Recommendation No.7).

Option No. 3: Balance Billing Statutory Formula - MedChi would support making the present statutory formula for the reimbursement of non-contracting physicians more transparent. MedChi views with great skepticism the proposal (Option 3.2) to extend the current law to PPO and EHO products which it believes will already compound the difficulties particularly if health insurers are "protected" by state law from paying non-participating doctors their billed charges. Similarly, Option 3.3 will further compound the present problem by having hospitals place pressure on doctors to accept unfair contracts from HMOs.

As indicated in its Recommendation No. 2, MedChi believes that the current statutory formula contained in Health General Article §19-710.1, can be improved by substituting the law of Colorado.

Option No. 4: MIA and Attorney General Authority - MedChi does not fully understand this Option but to the extent it would give the MIA or the Attorney General an ability to "penalize" doctors who "perform poorly," MedChi would object. The MIA should be penalizing insurers that "perform poorly" and not exercising judgment with respect to doctors for which that agency has no expertise.

Option No. 5: Physician Payment System - MedChi believes that Option 5.1 is worth pursuing as specified in MedChi Recommendation No. 6 but Option 5.2 is a more complicated proposal which should not be even considered until existing initiatives have played out.

Option No. 6: Pay For Performance (P4P) – P4P programs have generated enormous controversy in the medical community. The problem with P4P programs is that patients do not necessarily receive "quality" medical care because doctors perform according to a standard set of indices. This same notion was advanced in American business circles 30

years ago (Six Sigma) and proved not only time consuming but, ultimately non-productive, as it served to stifle creativity.

Nevertheless, as the present push for P4P continues, there should be standards on insurers to benefit both consumers and physicians in analyzing the P4P rating systems. National insurance carriers (for example, United) clearly want to export their agreement with New York to all other states.

Option No. 8: Increased Reimbursement For Certain Services – MedChi fully supports increased reimbursement for after hours and electronic services as mentioned in this Option but with one change: strike the word "encourage" and substitute the word "require." To the extent that state law "requires" fully insured plans to compensate doctors in certain ways, ERISA plans may follow suit as insurers do not form separate panels of doctors depending upon whether a patient is in an insured plan or an ERISA plan.

See MedChi Recommendation No. 3 which presents a fuller discussion of this particular Option.

Option No. 9: Mental Health Services - MedChi supports this Option which would assist primary care physicians in being reimbursed for the provisions of mental health services.

Option No. 10: Physician Shortages - MedChi would support Option 10.2 (See MedChi Recommendation No. 1), 10.3 and 10.5 (MedChi Recommendation No. 4 and Recommendation 5) with the proviso that Option 10.5 be edited to strike "and CareFirst."

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